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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **STEPHANIE JANE FALOON, aka** **STEPHANIE JANE STEWART** **3616 Cardiff Avenue, Apt. 208** **Los Angeles, CA 90034** **Registered Nurse License No. 537701** Respondent.	Case No. 2010-288 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about October 15, 1997, the Board of Registered Nursing issued Registered Nurse License Number 537701 to Stephanie Jane Faloon aka Stephanie Jane Stewart (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2011, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Code section 2761 states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

COST RECOVERY PROVISION

8. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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DRUG DEFINITION

9. Heparin Flush IV is an anticoagulant used to keep intravenous (IV) catheters open and flowing freely. Heparin helps to keep blood flowing smoothly and from clotting in the catheter by making an anti-clotting protein in the body work better.

SUMMARY OF FACTS

10. Since about January 1998, Respondent was employed as a registered nurse in the Pediatrics Unit (4NE) at Cedars-Sinai Medical Center (CSMC), Los Angeles. On or about November 18, 2007, while working as the day shift Charge Nurse at 4NE, Respondent's duties included overseeing and assisting other nurses in the unit with their patient load. Respondent's shift was from 7 a.m. to 7 p.m.

11. On November 18, 2007, Patient #1 and Patient #2, twins, were housed in the same room. Patient #1 was a 9-day old female infant admitted to 4NE on November 17, 2007 with a rash. Physician's order was for Acyclovir every 8 hours IV, and Vancomycin every 8 hours IV. Patient #2 was a 9-day old male infant admitted to 4NE on November 17, 2007 with a rash. Physician's order was for Acyclovir every 8 hours IV, and Vancomycin every 8 hours IV. Per hospital protocol, Heparin flush 10 units per milliliter is to be administered after the administration of IV medications.

Patient #1

12. On November 18, 2007, Patient #1 was initially assigned to Nurse Melanie Campbell. At about 0830 hours, Nurse Campbell administered Acyclovir to Patient #1. Between 0900 to 0930 hours, before the medication was completely infused, Respondent instructed Nurse Campbell to go on a break. While Nurse Campbell was on break, Respondent fed and changed the diaper of Patient #1.

13. At about 1000 hours, Nurse Campbell started the administration of Vancomycin to Patient #1 after her return from her break. Before the medication was completely infused, Respondent re-assigned Patient #1 to another nurse, Jennifer Antin.

14. At about 1030 hours, Respondent retrieved a Heparin vial and prepared the Heparin flush on Patient #1. Respondent did not document the preparation or administration of the flush.

15. On or about November 27, 2007, the County of Los Angeles, Department of Public Health investigated the incident and interviewed Respondent. Respondent admitted that she did not recall the dosage of Heparin flush used.

CAUSE FOR DISCIPLINE

(Gross Negligence)

16. Respondent is subject to discipline under Code section 2761, subdivision (a)(1) on the grounds of unprofessional conduct as defined under California Code of Regulations, title 16, section 1442, in that on or about November 18, 2007, while on duty as a Charge Nurse at 4NE at CSMC, Respondent was grossly negligent in her care of Patient #1 in the following respects:

a. At about 1030 hours, Respondent administered a Heparin flush after the infusion of Vancomycin, but did not chart in the patient file. Complainant refers to and incorporates all the allegations contained in paragraphs 10 – 15, as though set forth fully.

b. At about 1030 hours, when Respondent drew up a Heparin flush, she could not recall if she had checked the vial for the correct medication, concentration, route and absence of discoloration and particulate matter. Complainant refers to and incorporates all the allegations contained in paragraphs 10 – 15, as though set forth fully.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 537701, issued to Stephanie Jane Faloon aka Stephanie Jane Stewart;

2. Ordering Stephanie Jane Faloon aka Stephanie Jane Stewart to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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3. Taking such other and further action as deemed necessary and proper.

DATED: 12/7/09

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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